DOCUMENT RESUME

ED 068 865 CG 007 571

AUTHOR Campbell, Robert; Ash, Elizabeth
TITLE Attrition: A Study in a Community Mental Health Center and the Problems Involved.
INSTITUTION Washington Univ., Seattle. Bureau of Testing.
PUB DATE 72
NOTE 26p.

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS College Students; *Community Health Services; *Field Studies; *Mental Health Clinics; Mental Health Programs; Public Health; Research Methodology; Research Needs; *Research Problems; Research Projects; *Student Research

ABSTRACT

This report evaluates the success of a student project at a community mental health center both in terms of the reasons for client attrition and in terms of the difficulties of doing field research. The administration of the project was conducted by a class of 17 undergraduate psychology students. The subjects qualifying as dropouts were people who had made initial contact with the center, i.e., had been processed through intake, but had failed to keep subsequent appointments. In general, it was concluded that the project was disorganized. The student workers looked for direction from the mental health center staff, only to be confused by different sets of answers. It was suggested that in the future student researchers be organized in a three-week workshop on interviewing techniques. The response to counselors was generally found to be positive. A number of specific suggestions from clients were also presented. (Pages 11 and 12 may be illegible.) (Author/BW)

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August 1972

Attrition: A Study in a Community Mental Health Center and the Problems Involved

Robert Campbell and Elizabeth Ash

This report evaluates the success of a student project at Harborview Community Mental Health Center both in terms of the reasons for client attrition and in terms of the difficulties of doing field research.

Bureau of Testing Project: 235

Attrition: A Study in a Community Mental Health Center and the Problems Involved

Robert Campbell and Elizabeth Ash

Under new federal funding for community mental health facilities Harborview Community Mental Health Center (HCMHC) was established to serve the central district of Seattle, Washington. This service has now been in operation for one fiscal year. In the process of evaluating the overall program the directors of the Center became concerned with what seemed to be a large attrition rate. It should be noted that the Harborview catchment area is largely comprised of people of lower socioeconomic class. Overall and Aronson (1963) report that treatment expectations of the lower status patient and the fulfillment of these expectations are directly related to their returning for further treatment.

With this in mind the Harborview research team designed a project to study possible causes of attrition in the area they serve. The actual administration of the project, however, was conducted by a seminar class of 17 undergraduate psychology students from the University of Washington. The students were participating in a seminar entitled "Introduction to Clinical Psychology" (Psychology 448, Winter and Spring Terms, 1972) taught by Patricia Lunneborg. Their interest in the project was in obtaining some field experience in the area of clinical psychology. Two HCMHC staff members, Aline La Flamme and Ralph Hayes, supervised the work done.

The research team decided that subjects qualifying as dropouts would be people who had made initial contact with the center, i.e., had been processed through intake, but had failed to keep subsequent appointments. In order not to bias the interviewing process students had no a priori knowledge of the individual patient's problems.

The research team had several prior assumptions as to the causes of the dropout rate, ideas closely parallelling the general assumptions stated in Richardson and Cohen (1968):

1. Failure to return for further services at the Center indicated dissatisfaction with the service received.
2. The patient had not been helped through the contacts with the Center.
3. Professional time and effort had been wasted and should be redirected to better serve the community.

It was thus hoped that this study, while searching for the reasons for attrition, would point up the critical areas for improving services and for best redirection of resources.

The study ran from January to June 1972. June 2nd was arbitrarily chosen as a cutoff date for data collection and the sample at that time consisted of 150 subjects. The master files of the HCMHC were culled for the names of those patients who for the period January 1, 1971 - June 2, 1972 had been in to the Center for a single appointment and who had never returned. Enough information for each patient to be contacted was transferred to a "Follow-Up Form." This form (see Appendix 1) contained information such as name, address, phone, next of kin, employment status, etc. The student interviewers were given a number of these follow-up forms and attempted to make contact with those patients and interview them, asking questions from a standard questionnaire (Appendix 2). When one caseload, usually five patients, was exhausted by an interviewer, a new caseload was assigned. On the basis of final disposition of the case, it was possible to place each patient in one of four categories:

a) Completed interviews. These patients were contacted. They agreed to a personal interview and answered the questions on the questionnaire.

b) Letters. In some cases patients were not able to be contacted personally, but a mailing address was found. A questionnaire was mailed to these people together with a standard letter (see Appendix 3) briefly explaining the project and asking for their cooperation in

filling out and returning the questionnaire to Harborview. A self-addressed, stamped envelope was enclosed. Of the patients who were sent a letter, not a single one returned the questionnaire.

c) Incompletes. These cases were assigned in May. By the cutoff date they had not been contacted but resources had not been exhausted.

d) Rejects. This category included those patients with whom contact was impossible; those whom all resources failed to locate, and those who, when contacted, refused the interview.

Table 1 shows the number of cases in each of these four categories. Table 2 gives the reasons why patients in the last three categories were not interviewed. The majority were never contacted: either they had moved away, available resources were incorrect or insufficient to locate them, or they were unavailable. Five people denied ever having been to HCMHC, contradicting the Center's records. Seven people were contacted but refused the interview or were too disturbed to give it.

The only patient information on the entire sample of 150 was contained on the follow-up forms. Table 3 gives a breakdown of the sample by sex, age, ethnic group, and employment status, both for the completed interviews and all incompletes. In the sample as a whole, 60% of Ss were female, 40% male. Of those patients whose ages were known, 82% were under 40 years old, with the largest age category being from 21 to 30 years old. Restricting the sample to those whose ethnic group was known, 63% belonged to the white majority, while 23% were black. This discrepancy from the overall Seattle racial ratio is easily explained: HCMHC's catchment area includes Seattle's central area populated predominantly by non-whites. Only 15% of the total group were recorded as being employed. Only those who listed employment were placed in this category; the "unemployed" category includes all other responses, including blanks. The "typical" HCMHC drop-out in terms of these statistics is a white, lower-class female, unemployed and on welfare, in her twenties.

Table 1

Number of Subjects in Each Category

Completed interviews	44
Incompletes	23
Letters sent	29
Rejected	54
Total	150

Table 2

Reasons Why Patients Were Not Interviewed

	N	%*
Contact made (N = 12)		
Refused interview or too distrubed for it	7	(6)
Never at HCMHC	5	(5)
No contact made (N = 94)		
Moved away	44	(42)
Insufficient or incorrect resources	19	(18)
Hospitalized	4	(4)
Not at home, no answer to phone	18	(17)
Dead or dying	2	(2)
No reason given	7	(6)
Total	106	

*Percentages are expressed in terms of the total.

Table 3

Demographic Data on All Subjects (N followed by %)*

	Completed Interviews (N = 44)	Incompletes (N = 106)	Total (N = 150)
Sex			
Male	9 (20)	51 (48)	60 (40)
Female	35 (80)	55 (52)	90 (60)
Age			
< 20	6 (13)	14 (13)	20 (13)
21 - 30	16 (27)	42 (40)	58 (39)
31 - 40	6 (13)	21 (20)	27 (18)
41 - 50	4 (9)	9 (8)	13 (9)
51 - 60	2 (4)	6 (6)	8 (5)
> 61	0 (0)	2 (2)	2 (1)
Unknown	10 (24)	12 (11)	22 (15)
Ethnic Group			
Caucasian	21 (47)	64 (61)	85 (57)
Black	12 (27)	17 (16)	29 (19)
American Indian	2 (5)	7 (6)	9 (6)
Other	0 (0)	2 (2)	2 (1)
Unknown	9 (21)	16 (15)	25 (17)
Employment Status			
Employed	7 (16)	16 (15)	23 (15)
Unemployed Incl. Blank	37 (84)	90 (85)	127 (85)

*Percentages are expressed in terms of respective totals.

Table 4 gives a tabulation of the answers to each question on the questionnaire. The term "other" was used to include all other responses than those previously listed for that question, including unknown and blank. For the most part, the number of answers sums to 44; if the sum is greater than 44 it was possible to place a subject's answer in more than one category. For the most part the answers are self-explanatory, but certain questions deserve further comment.

Question 1: "Other agencies" include Western State Hospital, Highline CMHC, Crisis Clinic, sychiatric Clinic of the University of Washington, Lewis Bishop House, and the Department of Public Assistance.

Question 6: Answers were divided into five specific categories and one "other" category, depending on whether the patient wanted counseling of any kind, including marital counseling; medical treatment, such as medications; treatment specifically for mental problems; expanded resources (one woman wanted a place to do some sewing); or just an opportunity to talk to someone.

Question 7: If the counselor was helpful, the patient either viewed him/her as a supportive personality; as being therapeutic, and helping to ease some (emotional) pain; as introducing the patient to new resources (such as referral to another agency, providing medications, etc.) Three patients found the counselor's non-directive approach unhelpful; two patients felt the counselors were non-personalized, only asked form questions, didn't really care.

Questions 8, 9, and 10: Patient's feelings about the counselor as a person and as a counselor and the patient's perception of the counselor's feelings to the patient were classified as positive, negative and other. Positive feelings include such responses as: good, nice, helpful, OK, understanding, fine, concerned, she liked me, good relationship, pleasant, straightforward. Negative feelings include: I didn't care for her, not too concerned, had lots of problems, didn't care, I was just another face in off the street, immature, unqualified, incapable, unorganized, mumbled to herself all the time.

Table 4

Responses to the Questionnaire

1. How did you first hear about the center?

	N	%*
Harborview hosp.	11	25
Family or friends	8	18
Doctor	5	11
Other agencies	19	43
Other	1	2

2. What was your means of transportation to HCMHC?

Bus	8	18
Car	8	18
Walking	12	27
Family or friends	9	20
Other	7	16

3. How long did you wait before seeing a counselor?

Less than 30 min.	19	43
31-59 minutes	5	11
One to 2 hours	6	15
More than 2 hours	4	9
Other	10	23

4a. Were you asked things that you considered too personal?

Yes	9	20
No	31	71
Other	4	9

4b. ---About your finances?

Yes	5	11
No	35	80
Other	4	9

4c. ---About your ability to pay?

Yes	4	9
No	34	77
Other	6	15

4d. ---About your background?

	N	%*
Yes	14	32
No	26	59
Other	4	9

5. Were you treated with respect?

Yes	38	87
No	1	2
Other	5	11

6. What sort of help were you looking for?

Counseling	13	30
Mental health treatment	9	20
Medical treatment	3	7
Talk	5	11
Resources	2	5
Other	9	20

7a. Was the counselor helpful?

Yes	32	73
No	5	11
Other	7	16

7b. How was the counselor helpful?

Supportive	11	25
Therapeutic	10	23
Resources	6	15

7c. How was the counselor not helpful?

Non-directive	3	7
Non-personalized	2	5

8. How did you feel about the counselor?

Positive feelings	33	75
Negative feelings	6	14
Other	5	11

*Percentages of the sample total of 44.

Table 4 Continued

9. How did the counselor feel about you?

	N	%*
Positive feelings	26	59
Negative feelings	8	18
Other	10	23

10. How did you feel about him or her as a counselor?

Positive feelings	34	77
Negative feelings	6	15
Other	4	9

11. Did the counselor understand your problems?

Yes	29	66
No	8	18
Other	7	16

12. Were you asked to come back?

Yes	31	71
No	6	15
Other	7	16

13. Were you given an appointment?

Yes	18	41
No	22	50
Other	4	7

14. What sort of treatment was recommended for you?

Group	14	32
Medication	6	15
Hospitalization	2	5
Med group	1	2
Individual counseling	8	18
Day treatment	2	5
Other	16	36

15a. Is this what you were expecting?

Yes	16	36
No	18	41
Other	10	23

15b. If not, what were you expecting?

	N	%*
Patient had specific expectations	10	23
Patient had non-specific expectations	10	23

16. Why didn't you come back?

Transportation, inconvenience	7	16
Referred elsewhere	7	16
No appointment	2	5
Problem was solved	13	30
Problem was not solved	13**	30
Other	2	5

17. What do you think is the role of the community mental health center?

Community and education	4	9
Dealing w/emotional problems	9	20
Referral to other agencies	2	5
Crisis intervention	1	2
Specific "help"	4	9
Non-specific "help"	16	36

18. Do you have any suggestions to help improve our service?***

Physical plant, length of wait	6	15
Administrative order, efficiency	5	11
Resources and services	5	11
Counselors	6	15
Intake, follow-up Background questions	2	5
Other	5	11

* Percentages of the sample total of 44.
** These 13 answers are written out as Appendix 4.
***All suggestions are written out as Appendix 5.

Question 15: Twenty patients reported that their experience at HCMHC was not what they were expecting. Ten of these patients had specific expectations (pills to lose weight, one-to-one counseling, medications). An equal number of patients had non-specific expectations (didn't know what to expect, a more business-like, hospital situation, they were quicker, more efficient than I expected).

Question 16: This was surely the key question of the questionnaire. Some persons did not return because they lacked transportation or it was inconvenient to do so. Seven patients were referred elsewhere, and two were not given an appointment to return and therefore didn't. Thirteen patients reported that their problem had been solved and there was no need to return (crisis passed, thoughts sorted out, felt better, didn't need any more medication) while an equal number didn't return because their experience at HCMHC did not solve their problem. The responses of these thirteen patients are included as Appendix 4.

Question 17: Subjects viewed the role of the community mental health center as one of education and a community role; a source of referral to other agencies when the Center is unable to help; a resource for crisis intervention; a resource for dealing with emotional problems specifically; a source of specific "help" (but not specifically emotional problems)--this included medication prescription, drug addiction control, simply talking with people; the largest number of respondents suggested that the Center should offer some kind of unspecific "help" ("Something to do with help for those in need.")

Question 18: Suggestions for improving the service at the center were directed toward the physical appearance of the center and the length of wait before seeing a counselor; red tape, efficiency, and administrative organization; availability of resources and services; specific suggestions for the counselors; and suggestions involving the intake, follow-up, and background questions. Twenty-five suggestions were made; these are Appendix 5.

The discussion divides logically into two sections. The first concerns attrition at HCMHC as discovered by this research project: it is a partial answer to the question, "Why don't people return to HCMHC

after a single interview?" The second section concerns the research project itself, the ways in which it succeeded and failed. "What accounts for the dissatisfaction voiced by the interviewers? How could this project have been better and how can the next evaluation project be better?"

Attrition. Unfortunately, control information is unavailable: information about those persons who, during the time period studied, did in fact return to the Center. Without knowing the number of persons who did return it is impossible to construct an attrition rate. Likewise, without statistical information for the continuers as is available for the sample (age, sex, ethnic group, employment status) it is impossible to draw valid inferences concerning the characterics of non-continuers. Examining the data obtained is the best that can be done.

Of the sample of 150 less than one-third were actually interviewed. While this is partially due to the inexperience of the interviewers and their unfamiliarity with the various resources needed to trace people, it is nonetheless true that the HCMHC clients are predominantly of lower socioeconomic status and many had not been in to HCMHC for a year or more. Since then they had left their previous address without leaving a forwarding address; few could be contacted through their job since few were employed; many were discovered to be, to the growing frustration of interviewers, "transients" who faded from one Skid Row hotel or doorway to another. Most of the persons who were not interviewed simply could not be found: they had moved away, or could not be located or seemed to be never at home.

The ratio of females to males in the sample was 6 to 4. This corresponds closely to a similar study by Brigg (1965) in which 64% were female, 36% male, and a study by Kidd and Euphrat (1971) which found the same ratio, 64% female to 36% male. It is not known whether this unbalanced sex ratio is due to a higher tendency for lower class females to enter and then drop out of therapy than lower class males. Four times as many females as males were interviewed, but most interviews occurred during the day when males were likely to be gone from the house. Although

several studies reported an unequal number of female to male clients, nothing explained this fact and further inquiry into this facet of community mental health is indicated.

A startling minority (15%) reported themselves to be employed. On many of the follow-up forms, however, this was left blank, due either to the patient's or the student filer's omission or unwillingness to record that information. Despite the socioeconomic status of the clients at HCMHC, 15% is probably an underestimate of actual employment.

Twenty-nine letters were sent out; not a single one was returned. Trying to reach distant subjects of the sample in this way may be regarded as a brave attempt but a total failure.

The answers to the questionnaire yielded the most information. The majority of those clients who responded to the questionnaire reported that they waited for less than an hour; were not, in the intake, asked questions which were too personal, either about finances or their background; were treated with respect and understanding; saw the counselor as helpful; had positive feelings to the counselor as a person and as a counselor; felt that the counselor felt positively toward them; were asked to come back. However, only three of them did so.

Why, then, did they not return? Seven persons were referred elsewhere and thus were not expected to return; thirteen reported that their problems had diminished or been solved and thus needed no further treatment. Brigg (1965) and Morris and Soroker (1953) have suggested that in some cases this response may not be truthful: if put off by a long waiting period a client may maintain that his problems have cleared up by themselves as a defense ("See, I didn't need those stupid counselors anyway"). For others, the first interview may clarify for the patient what he wants, where he is and how much of himself he is ready to invest in therapy. This requires some desire for change of his situation and willingness to put some effort into it. Thus, the very first appointment may help some patients to clear their problems by themselves.

Twenty-two patients (50%) reported that their problems had not been solved, that it was too inconvenient to return, or that they had not come back because they had not been given an appointment. This suggests three things: that first-time clients be informed of transportation resources (Seattle Transit); that they be informed of the Center's resources (Daycare, recreation facilities, etc.); that those persons who expect to return be given an appointment to return--some persons will not otherwise come back. The responses of those 13 people who reported that their problem had not been solved are shown in Appendix 4. It will be noted how vague are most of these responses ("Communication differences," "People bugged me, groups made me nervous").

One of the most important factors concerning client attrition, and one which was not sufficiently investigated concerns the expectation of both the client and the therapist as to what will occur in therapy. Many persons who come to a mental health center to "get help" are doing so for the first time and have the vaguest expectations; many believe they are going to see a "shrink" who will tell them what is wrong with their heads and how to change it and what medications to take. The counselor, on the other hand, has his or her own expectations concerning therapy which are likely to be quite different from the client's. Heine and Trosman (1960) suggest that patients subscribe to the "guidance-cooperation" model, while therapists subscribe to a "mutual-participation" model, in which they expect:

1) The patient should desire a relationship in which he has an opportunity to talk freely about himself and his discomforts.

2) The patient should see the relationship as instrumental to the relief of discomfort, rather than expecting discomfort to be relieved by an impersonal manipulation on the part of the therapist alone.

3) Hence, the patient should perceive himself as in some degree responsible for the outcome (p. 278).

It is unfortunately impossible to tell from the responses to the questionnaire just what the clients' expectations were. Sixteen persons

reported that they got what they expected, and 18 reported they did not get what they expected. Ten persons had specific expectations which they said were not fulfilled; ten others had non-specific unfulfilled expectations. The answers were again for the most part vague: "Didn't think they would be so nice," "Wasn't right for me," "Didn't know what to expect." Several were disappointed not to receive individual counseling; others were dismayed at the youth and supposed inexperience of the counselors; a few wanted medications which they did not receive. Understandably, few persons expressed their expectations concerning the mode of therapy, but if their expectations and their counselor's are not complementary the therapeutic relationship may be disrupted.

What can be done? Therapists' and clients' expectations, and possible discrepancies between them, must be considered if therapy is to be likely to be meaningful, and this should be done at the client's first session. Oxley (1966) suggests

> 1) The diagnostic assessment of a client should include his expectations of agency service and his expectations for himself. In order to "begin where the client is," the social worker needs to be fully aware of his hopes and expectations.
>
> 2) The worker should set his expectations in the upper range of what is realistically possible, after a careful assessment of the client's potential and problems and the available resources. Low expectations provide no motive either for the client or for the worker.
>
> 3) The worker should assess the discrepancy between his and the client's expectations. If it is of major proportions, the worker should take the responsibility for, and initiative in, reconciling the difference.
>
> 4) Workers must know the current resources in their communities. Workers need to know the nursing homes, the medical facilities, the mental hygiene centers, the child care agencies, the employment possibilities, and the communities' attitude toward minority groups.
>
> 5) There is need to learn how to make specific expectations effective in motivating a client. Expectations must be perceived in order to influence behavior. Expectations must be perceived by the client as legitimate in the context of his current situation

> and his culture. The worker must be free to sanction with realistic encouragement and approval whatever steps toward growth the client takes and to employ negative sanctions by raising questions and occasionally expressing discouragement and disapproval. (Pp. 435-436)

Critique of Project. Reporting of the attrition research done for Harborview must necessarily include an evaluation of the problems and difficulties inherent in the project. There is no way of determining what differences in results would have come from other methods, however, consideration has been made of the materials, methods and planning of the project, with the following conclusions. In general, the project was disorganized. The student workers looked for direction from the HCMHC staff, only to be confused and frustrated by different sets of answers. There existed lack of coordination between staff to staff, staff to student, and student to student. In a sense the students felt they could provide a valuable service to the Center and its clients but were caught in a double bind. On the one hand they were told that this was their project, that they were free to proceed as they saw fit. Yet, on the other hand, they were constantly being instructed on what to say and do. The study should either have been directed by those who conceived it if they had certain expectations as to procedures, or else the students should have been free to conduct their own devised study.

It is suggested that in the future student researchers be organized in a three-week workshop on interviewing techniques. Even though primary interest was directed toward the project, any contact with prospective clientele should focus directly on them and their problems. That is to say, with more experience in interviewing, the process could have better indicated concern for the individual, while at the same time gathering pertinent information. The students felt their perceptions should have been allowed to enter into the data as to why clients did not come back, i.e., "What I think this person is really saying." The questionnaire was organized to elicit one word or very brief answers. Had the questions been more open-ended, and had there been greater allowance for discussion, the students might have been able to uncover those very real reasons for

attrition that have more to do with clients' expectations than "transportation difficulties" or "we solved our own problem." As it was the questionnaire was to be administered in a routine fashion, "Please answer X question." Students would have liked to have made the patient contact more of an opportunity for the client to open up about feelings about their problem or their concept of treatment. This small amount of follow-up contact was perceived by many as a positive indication of interest on the part of the community mental health center. It can be seen that this type of contact has a great amount of potential for serving the community. It should be enhanced in every way possible.

There were several mechanical problems with working at the Center. Necessarily there was a great amount of data to be collected and organized. Students' efforts in this area were hampered by lack of upkeep in the HCMHC clientele files. Some client cards were not annotated at all or inadequately. Papers were spread in different places, with no systematic noting of location, or else the system was not used. Many case histories were incomplete, causing some clients who had been coming in regularly for treatment at HCMHC to appear as attrition subjects. Contact with these persons indicated lack of care and concern on the part of the Harborview staff. Also the charts were not always available, although no one knew where they were. Here too, there was much confusion as to who should have access to the files. Although for confidentiality reasons it is understandable that the files should not be publicly open, easy access to them for data collection would have significantly improved this project.

Generally, the atmosphere at the Center was observed to be extremely relaxed, to the point of inefficiency. While a casual, friendly atmosphere is desirable in this setting, the Center must still function as an operating unit providing service to the community. Too many times staff were not available for assistance, although no one knew where they were. This could greatly hamper scheduled activities within the Center and is generally considered a "cop-out." The Center is new and

constantly in a state of flux, but while flexibility is good, so too is stability. Attitude is important too. Dissatisfaction among workers is conveyed in many ways to clientele.

The class as a whole had several suggestions to improve the first contact with a client, perhaps thereby reducing the rate of attrition. First of all, the intake should be conducted in as open a manner as possible. Data can be obtained in ways other than straight question-answer. Much significant material is conveyed in a casual situation. This should be listened for. The class felt that questions like "How did you learn about sex" are not significant in all cases. During the initial contact the counselor should find out why a client has come in, what he expects to find and then proceed to create the best plan of future action.

It is also extremely important, as the data indicate, that new patients be queried about their transportation means--is transportation going to be a problem in the future? If so, the counselor should advise the client of the Seattle Transit System and give specific directions for coming to the center on the appointment.

The response to counselors was generally found to be positive. Most clients felt they had been treated with respect. It is significant that several people would just like to be able to come in to rap with someone. Maybe the Center could use some older volunteers that have had contact themselves with the Center in this capacity. More specific suggestions from clients are in Appendix 5.

Appendix 1

FOLLOW-UP FORM

Date last seen_____ Date filed_____

Name_____ Sex_____

Address_____ Age_____

Phone_____ Employment Status_____ Ethnic Group_____

Source of Referral_____

Next of Kin/Friend/Other:

Name_____ Phone_____

Address_____ Relation_____

NOTES:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed by_____

Appendix 2

QUESTIONNAIRE

1. How did you hear about the Center?

Newspaper, Radio, etc.	___	Court	___	
Family or Friends	___	Agency	___	Specify_____
Harborview Hospital	___	Other	___	Specify_____

2. What means of transportation did you use to come to the Center?

Bus	___	Walk	___
Car	___	Friends brought	
Other	___ Specify____	you	___

3. When you came to the Center how long did you wait before seeing a counselor?

_____(Hrs.)

4. Were you asked things that you considered too private or personal?

Yes ___ No ___

About your finances?	Yes ___	No ___
About paying for treatment?	Yes ___	No ___
About your background?	Yes ___	No ___
Other_____ Specify_____		

5. Were you treated with respect? Yes ___ No ___ Comment_____

_____

6. What sort of help were you looking for? _____

_____

_____

_____

7. Was the counselor helpful? Yes ___ No ___

If Yes, what was helpful? _____

_____

If No, what was not helpful? _____

_____

Questionnaire
Page Two

8. How did you feel about the counselor? _____

_____

9. How do you think the counselor felt about you? _____

_____

10. What did you think of him as a counselor? _____

_____

11. Did the counselor understand your problems? _____

_____

12. Did the counselor ask you to come back? Yes ___ No ___

13. Were you given an appointment? Yes ___ No ___

14. What kind of treatment was recommended for you? (pause)

Group Therapy	___	Individual Counseling	___
Medication	___	Day Treatment Program	___
Hospitalization	___	Other ___ Specify _____	
Medication Group	___		

15. Was this what you were expecting? Yes ___ No ___
If No, what were you expecting? _____

_____

16. What kept you from coming back? _____

_____

17. What do you feel the role of the Mental Health Center is? _____

_____

18. Are there any suggestions you could make to help us improve our service?

_____

_____

_____

_____

_____

Community Mental Health Center

925 Terrace Street, Corner of Terry & Terrace

Seattle, Washington 98104

February 23, 1972

Mr. Ralph Hayes
925 Terrace Street
Seattle, Washington

Dear Mr. Hayes:

We are presently talking to the people who have been at our Community Mental Health Center at Harborview. We are doing this to get as many ideas as possible so that we can improve our services.

We've been unable to contact you by telephone to arrange a personal interview. Enclosed then, is a questionnaire which we would like you to fill out and return to us as soon as possible. The information you give will be kept confidential, so please feel free to tell us what you think about our program. Your ideas are important to us and will help many others who come here.

Thank you for your assistance and we hope to hear from you soon.

Yours very truly,

John Doe

If you would rather arrange a personal interview with us, please call MU 2-3050, ext. 610. Preferably Tuesday or Friday 9:00-5:00.

Appendix 4

1) Got sick-stomach upset. Counselor shouldn't ask what he can do for me.
2) Answering all the questions didn't do any good.
3) The run-around about next week--by that time I would have worked out my problems.
4) People bugged me. Groups made me nervous.
5) I feel individual counseling would be better. For that kind of money ($47.50) I could go to a psychiatrist and did so.
6) It didn't fulfill needs--I didn't want group counseling but individual counseling.
7) I didn't think it would fulfill needs; tired of talking; mad at "meds."
8) Didn't think it would help; lack of transportation.
9) Divorce (Had been in for marital counseling).
10) Too many hassles, no solution to my particular problem, wasting time.
11) No help. I disliked the counselor.
12) Communication differences.
13) Not getting help for my problem.

Appendix 5

1) Too much going on in office area.
2) Let people know what's going on. Be clearer to patient about what they're supposed to do. It would be more comforting if the staff looked like they knew what they were doing.
3) Wait is too long, waiting room too small.
4) Educate the public so mental patients aren't discriminated against. Counselor should be less educated, older, and more understanding. Organize so patient doesn't have to wait.
5) Public transportation to the Center.*
6) More personnel.
7) Wait is too long; not enough doctors.**
8) Medicine, treatment, books, reading.
9) Friendlier counselors, more than one branch. Home visits if possible.
10) Less meds, less tests, a more relaxing atmosphere, don't rush people. Make people feel their problems are important.
11) Get rid of stigma. Don't use drugs unless violent. Have personnel more concerned, not just putting in time. Counselors too young and inexperienced. Change laws enabling relatives and friends to commit patients.
12) Provide transportation. Have more people to just rap with people. Be realistic about problems. Should be neighborhood centers, not just a central location.
13) Individual treatment.
14) Daycare should be extended. Not enough time to get into anything.
15) Secretary efficiency in relaying messages.
16) Appearance of Center--floors dirty, drab. Only do what patient wants to receive.
17) Too much red tape and useless paperwork. Interviewer asked too many personal/financial questions. Waiting room is too small. Intake was unnecessary and expensive. More personnel and more neighborhood centers.

* Suggested by two subjects.

** Suggested by three subjects.

Appendix 5 Continued

18) Background questions unnecessary.

19) Keep in touch with patients.

20) Don't have anyone that doesn't care about people on the front desk (Intake counselor). Should offer more than "come back in two weeks."

21) People without training should not be counselors. Should have ethnic variety on the staff so if desired patient can see someone of the same race.

22) Lacks administrative order; need older therapists.

23) Atmosphere too informal. Drug addiction is the real problem: Go after the pin pushers and pot smokers.

24) Be more accurate in updating records.

25) Have an on-duty psychiatrist all the time. Have sensitivity sessions in the Fritz Perls vein.

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